

**COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH**

Application For Care And Treatment On A Conditional Voluntary Basis
M.G.L. Chapter 123, Sections 10 & 11
(made by Guardian With Authority to Admit)

Name of Patient (Ward) _____ <div style="text-align:center"><small>please print</small></div>	
Address: _____ City/Town _____ State _____	
Social Security Number: _____ Date of Birth: _____ Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Name of Guardian _____ Phone #: _____	
Address: _____ City/Town _____ State _____	
To the Superintendent (or other head) of _____ <div style="text-align:center"><small>Name of Facility</small></div>	
<p>1. I am the legal guardian of the above-named patient with special authority to consent to his/her admission to this facility. A copy of the guardianship order establishing this authority is attached.</p> <p>2. I wish to admit my ward as a patient at the above facility.</p> <p>3. I realize that when I want my ward to leave the facility, I must give written notice to the Superintendent of the facility, who may delay my ward's departure for up to three days (excluding Saturday, Sunday and holidays).</p> <p>4. Once I give notice that I want my ward to leave the facility, I realize that if the Superintendent thinks my ward might be a danger to himself or herself or other people because of mental illness, he or she may petition the District Court within the three-day period seeking to have my ward committed to (ordered to stay at) the facility for up to six months. The Court will schedule a hearing. My ward has the right to be represented by an attorney at the hearing. If he or she cannot afford an attorney, the Court will appoint one. After the filing of the petition, the Court has five (5) business days to begin a hearing on my ward's commitment. During this time, my ward must remain at the facility. At the hearing, the judge will decide whether or not my ward can leave the facility.</p> <p>5. I agree to my ward's receiving treatment at this facility for mental illness. I understand that this agreement does not limit my ward's right to refuse at any time specific treatment interventions such as antipsychotic medication, electroconvulsive therapy or psychosurgery.</p> <p>6. I have been given a copy of my Notice of Rights (Form CV-301G).</p> <p>7. I have been offered the opportunity to consult with a lawyer or paralegal concerning the effect of a conditional voluntary admission.</p> <p>8. I understand that the facility will accept or reject this application in accordance with the applicable clinical and legal standards.</p>	
_____ Signature of Guardian	_____ Date
_____ Witness	_____ Date

**ATTACH COPY OF GUARDIANSHIP PAPERS INDICATING SPECIAL AUTHORITY
TO CONSENT TO ADMISSION**

ACCEPTANCE/REJECTION BY THE FACILITY

The following questions shall be answered, and the application shall be accepted or rejected, by a designated physician* of the facility.

1. This patient

A. has been diagnosed with mental illness, as defined in 104 CMR 27.05 (1).

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

B. is in need of care and treatment for this mental illness,

<input type="checkbox"/>	<input type="checkbox"/>
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C. is in need of hospitalization (i) for such care and treatment or (ii) to prevent serious harm due to the absence of a more appropriate placement alternative.

<input type="checkbox"/>	<input type="checkbox"/>
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2. This facility is suitable for such care and treatment.

<input type="checkbox"/>	<input type="checkbox"/>
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3. The court order or decree giving the guardian authority to consent to hospitalization, or otherwise ordering hospitalization, has been reviewed and has not expired.

<input type="checkbox"/>	<input type="checkbox"/>
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If every box is checked "Yes", then the application shall be accepted unless the patient has not yet been admitted, in which case the application may be accepted only if the facility's criteria for admission have been met. If any box is checked "No", the application shall be rejected, unless only boxes "1.A", "1.B.", or "2" are checked "No" and the patient's continued voluntary hospitalization is necessary to prevent serious harm due to the absence of a more appropriate placement alternative.

The guardian may not sign a three-day notice until this form has been accepted.

I, a designated physician* of this facility, hereby (check all applicable boxes):

4. ☐ **Accept** this application for conditional voluntary hospitalization:

☐ A. Guardian is applying for admission and all criteria for admission are met.

☐ B. Only boxes "1.A", "1.B" or "2" are checked "No" and continued hospitalization is necessary to prevent serious harm due to the absence of a more appropriate placement alternative.

5. ☐ **Reject** this application for conditional voluntary hospitalization. Reasons:

Designated Physician's Signature

Date

Printed Name

Title

This patient's Conditional Voluntary status must be reassessed at the time of each periodic review.
FILE IN PATIENT'S RECORD IMMEDIATELY

* A physician who meets the criteria in 104 CMR 33.03